STATE OF CONNECTICUT
STATE TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106
Toll Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.state.ct.us/trb

TRB SPONSORED HEALTH PLAN OPEN ENROLLMENT FOR JANUARY 1, 2004

Health Coverage Change Requirements

This is your annual opportunity to add or cancel coverage to your health insurance options through CTRB. If you are adding or dropping or canceling all of your coverage, complete the enclosed form and return it to the above address. Two change forms are enclosed with this notice. If a member and a spouse both have changes, you must each complete a separate form. Forms must be received in this office by October 24, 2003. If you are not adding or canceling coverage, please disregard this notice.

Once you enroll in a specific plan, you may NOT make any changes until the next open enrollment period (effective date January 1, 2005) unless you are canceling entirely out of all coverage.

New Rates Effective January 1, 2004

Coverage Type	Per Individual
Medicare Supplement with Prescriptions	$51.00
Medicare Supplement with Prescriptions and Dental	$84.00
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$88.00

The above rates reflect one quarter of the total premium. Effective July 1, 2005, the rates will increase to one third of the total premium.

Coverage Changes Effective January 1, 2004

- The maximum annual out of pocket cost for prescriptions will remain at $1,000. Upon reaching this limit, your prescriptions will be filled at no cost to you for the remainder of the calendar year.

- Major medical maximum will increase to $1 million from the current $100,000 limit.

- Vision benefits will increase as follows:

	Current Benefit	New Benefit
Single Vision	$ 30.00	$ 60.00
Bi-Focal	$ 40.00	$ 80.00
Tri-Focal	$ 60.00	$120.00
Lenticular	$100.00	$200.00
Frames	$ 40.00	$ 80.00
Contact Lenses	$160.00	$320.00

- Hearing aid reimbursement will increase from $500.00 to $750.00.

- The additional 120 days of coverage in a Skilled Nursing Facility (after the Medicare benefit of 100 days has been exhausted) will be eliminated.

Claims/Coverages

When filing claims, please be aware that retirees and spouses enrolled in any of our plans have individual coverage. All claims should be filed as "SELF" with your own social security number regardless of whether you are the retiree or the spouse.

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Website www.state.ct.us/trb

HEALTH INSURANCE CHANGE FORM

This form is to be completed by members and spouses who are currently enrolled in a TRB Health Plan and are adding, dropping or terminating coverage.

- Submit a copy of your Medicare card even if you are currently enrolled in a Stirling & Stirling plan and wish only to change your coverage.
- ONE FORM FOR EACH PERSON CHANGING COVERAGE MUST BE RECEIVED BY OCTOBER 24, 2003.
- All changes will be effective JANUARY 1, 2004.
- **DO NOT SUBMIT THIS FORM IF YOU ARE STAYING IN YOUR CURRENT PLAN**.

	Cost per person Per month	**Check One(X)**
Medicare Supplement with Prescriptions	$51.00 monthly	☐
Medicare Supplement with Prescriptions and Dental	$84.00 monthly	☐
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$88.00 monthly	☐
Cancel all TRB coverage effective January 1, 2004		☐

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name	First	Initial	Home Phone

Street Address	City	State	Zip Code

Social Security Number	Medicare Number	Date of Birth

Enrollee's Signature	Date

If you are enrolling as the spouse of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number

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Enrollee's Last Name	First	Initial	Home Phone

Street Address	City	State	Zip Code

Social Security Number	Medicare Number	Date of Birth

Enrollee's Signature	Date

If you are enrolling as the spouse of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number